Consulting patterns: comparison between doctors' perceptions and patients' behaviour

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SUMMARY. Changes in the structure of a practice and the gender of the partners were accompanied by the abandonment of a personal list system. Doctors' opinions about the consulting behaviour of patients in the practice were determined by questionnaire. The notes of 100 patients registered with each of the six partners were examined to determine the nature and number of consultations with each doctor for the years 1980 and 1984. Doctors were found to be unaware of the reasons for which patients consulted different partners. In addition, doctors' opinions about how patients should consult did not correlate with patients' consulting behaviour. It was also found that women consulted the female partners in the practice more commonly than the male partners only after the number of women partners in the practice had increased from one to two.

Introduction

IT is claimed that personal lists facilitate better care of patients in general practice. They clearly identify which doctor is responsible for a patient's health and prevent the 'collusion of anonymity' where no partner takes decisions about difficult patients. Greater patient satisfaction and better compliance with treatment are also claimed.[1,2] However, combined lists offer other advantages such as reduced isolation of doctors, easier organization of appointment systems, increased choice for patients and reduced financial competition between doctors.[3]

The aims of this study were to investigate the following: how patients actually consult; what influence the patient's age, sex and presenting problem has on which doctor is consulted; what changes in consulting patterns there were after the expansion of the practice; and general practitioners' opinions of how patients should consult and why patients consult different partners.

Background

The study practice is situated in the midland town of Bedford, with a population of 77 000. In 1971 the practice was a partnership of three male doctors with a list of 8500 patients. When the senior partner retired he was replaced by a new male doctor. The practice policy at this time was that each partner looked after the patients registered with him and when any partner was away or off duty his patients were looked after by the other partners.

In 1978 the practice list size had increased to 9970 and the practice engaged an additional partner who was female. At this stage it was accepted that female patients registered with the male doctors might wish to consult the female doctor. Owing to marriage and family commitments the female partner has changed twice since then.

Between 1980 and 1984 one partner spent one year out of the practice on sabbatical, and two extra partners were engaged without a commensurate increase in practice list size. The list size in 1984 was 10 600. The consultation rate was 2.57 consultations per patient per year in 1980 and 2.49 consultations per patient per year in 1984.

Method

A questionnaire concerning the consulting behaviour of patients in the practice was distributed to the six partners. The questionnaire asked the partners how they thought patients should consult and what problems patients consulted particular partners about more than other doctors.

Ten male patients and 10 female patients aged one year, six years, 16 years, 50 years and 70 years on 1 January 1980 who had been continuously registered since January 1980 with each of the four doctors were selected from the practice age–sex register. These age groups were chosen to include toddlers, school children, young adults, adults and retired people. The notes of these 400 patients were withdrawn from the files and the nature and number of consultations with each doctor for the years 1980 and 1984 were recorded.

This process was repeated for patients aged four years, 10 years, 20 years, 54 years and 74 years registered with the two doctors who had joined the practice since 1980.

For the patients on each partner's list the number of consultations with that partner and with the other partners were calculated. The percentage of consultations for different problems with each partner was determined and the percentage of consultations with each partner was calculated for each age group and sex of patients.

Results

The doctors' perceptions of what was an ideal consulting pattern varied widely. Doctors 2, 5 and 6 valued the concept of a personal doctor (Table 1) while doctors 1, 3 and 4 valued continuity in one episode of disease or in long-term illness. The two women doctors, Doctors 4 and 5, felt that the responsibility for a family rests with the doctor they are registered with, whomever they consult, and Doctor 4 considered that patients benefit from being able to consult a range of doctors with a range of skills. Table 1 shows the number of patients consulting their own doctor in 1984. At this time Doctors 5 and 6 who had joined the practice after 1980 had a lower than average list size, while Doctors 1, 2, 3 and 4 who had joined prior to 1980 had comparable lists. The variation in the number of patients seen did not reflect the number of non-list commitments of the various partners. Despite Doctor 2 expressing a preference for patients identifying a personal or family doctor the percentage of patients on his list consulting him was the lowest in the practice and dropped between 1980 and 1984. Although Doctor 1 limited his perception of the value of continuity to one episode of disease, the percentage of patients on his list consulting him was the highest in the practice, and rose over this period.

All six doctors identified problems which they felt patients consulted them for more often than other doctors in the practice; comparison of the percentage of consultations for various diagnostic categories with their opinions recorded on the questionnaire showed that five of the six doctors' opinions were not

Table 1. Doctors' opinions of how patients should consult and the number of patients seen by their own doctor in 1984 from the records of 600 patients attending for 1499 consultations.

Doctor	Sex	Doctors' opinion of how patients should consult	List size	No. of registered patients consulting any doctor	No. (%) of own patients seen
1	Male	Continuity of care through any one problem	2354	252	134 (*53.2*)
2	Male	Always see the same doctor	2154	276	86 (*31.2*)
3	Male	See the same doctor for one disease episode and for long-term problems	2301	240	92 (*38.3*)
4	Female	See whichever doctor is free for acute problems and a personal doctor for continuing problems	1926	295	145 (*49.2*)
5	Female	Family should have allegience to one doctor	802	302	138 (*45.7*)
6	Male	One doctor should be the family doctor and a standby should be available when the family doctor is away	1065	134	69 (*51.5*)

accurate. Doctor 1 thought he saw more patients than average with asthma, menopausal symptoms and gynaecological problems but in fact saw a higher percentage of patients with injury and poisoning and cardiovascular disease than other partners. Doctor 2 incorrectly thought that patients were more likely to see him with depression, gynaecological problems and if they needed care rather than cure, in complete contrast to the higher numbers of patients with infections, respiratory disease, cerebrovascular problems and skin problems that he actually saw. Doctor 3 thought he saw more diabetes, hypertension and anxiety and depression than normal but his consultations included very many more screening and prophylactic procedures than other partners and similar numbers of other problems. Doctor 5 said she saw more gynaecological problems but in fact saw more mental problems and symptoms, signs and ill-defined conditions than most of the partners. Doctor 6 thought he saw more patients for contraception, failure to cope and sadness than other partners but results showed he did not see more of any particular problem. Only Doctor 4 correctly perceived that she saw more endocrine, digestive, genitourinary, pregnancy and family and social problems than other partners.

From the analysis of consultations during 1984 with patients in different age groups it was found that Doctor 1 saw a larger than average percentage of patients over 50 years, and Doctor 2 a smaller than average percentage. This agrees with Doctors 2's perception that he does not relate well to elderly patients. Doctor 5 incorrectly perceived that she saw more children than average in the partnership. In fact both the women doctors (4 and 5) saw a smaller than average percentage of babies, possibly because they tend to get rapidly booked up and cannot take urgent consultations, but Doctor 4 saw a larger than average percentage of children and young adults.

Table 2 summarizes the percentage of consultations in 1980 and 1984 by the sex of patients for each partner. There is a marked difference between the two years. Doctor 1 saw fewer women patients in 1984 than in 1980, Doctor 2 fewer men patients, and Doctor 4, a woman, more women patients. In 1984 both women doctors saw more women patients than the male doctors, and the ratio of male to female patients for the four male doctors was similar. However, in 1980 when there was only one woman doctor in the practice women patients did not consult the female doctor any more frequently than the male doctors.

Table 2. Percentage of consultations with each partner by the sex of patients.

Doctor	Sex of doctor	% of consultations in 1980		% of consultations in 1984	
		Male patients	Female patients	Male patients	Female patients
1	Male	*37*	*63*	*44*	*56*
2	Male	*56*	*44*	*48*	*52*
3	Male	*45*	*55*	*43*	*57*
4	Female	*49*	*51*	*32*	*68*
5	Female	–	–	*30*	*70*
6	Male	–	–	*47*	*53*

Discussion

The differences in consultation patterns revealed by this study are of interest and importance to the practice concerned but they may also have general relevance. Between 1971 and 1984 the agreement about personal lists among the partners in this practice largely disappeared. Some attempt at defining a personal doctor was still made but there was considerable variation between doctors in their perception of the usefulness of patients always being seen by their own doctor. Also the consultation pattern found did not reflect the degree to which partners valued the concept of a personal list. For example, Doctor 2, one of the three doctors in the practice in 1984 who felt that patients should always consult the same doctor, was consulted by the smallest percentage of patients registered with him. There may be many reasons for this, such as the fact that he tends to have more free appointments at the beginning of each day than the other doctors. Whatever the reason, the general finding in this study appears to be that doctors' perceptions are not matched by performance. This also applies to doctors' perceptions of the frequency with which they were consulted for different diagnostic categories.

Every partnership is unique in the mix of factors which influence consulting patterns. From this study, it seems likely that general practitioners have inaccurate perceptions of their own workload and they need to use objective measures when considering changes in working arrangements. Perceived unequal sharing of workload is a potent source of friction in general practice. Ideally, therefore, the monitoring of consultation patterns should be continuous so that trends and potential problems can be detected at an early stage.

References

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